BioSense programme falls under heavy scrutiny

For more information on **BioSense** see http://www.cdc.gov/phin/component-initiatives/biosense/index.html

When Farad Mostashari, assistant commissioner of the New York City Department of Health and Mental Hygiene, criticised the BioSense disease surveillance programme at a Washington health information technology meeting in April, charging, among other things, that it was poorly planned and lacking in analysts equipped to deal with its complexity, his harsh assessment was the latest in a series that included a critique from the Government Accountability Office last year and a US Senate bioterrorism subcommittee hearing in March.

BioSense is the infant US CDC programme to detect and monitor disease outbreaks. Critics were dismayed in part because BioSense collects its data directly from hospitals and other medical facilities, seemingly bypassing the local public-health infrastructure. Since the data were coming directly to CDC rather than being transmitted from local health departments, as in the past, local officials had the impression they did not have access to it.

Lynn Steele, director of the CDC's Division of Emergency Preparedness and Response, dismissed the criticism as incorrect. "We need to make sure our messages are clear", she said in an interview. Local public-health agencies are authorised to view local data at the same time as CDC. When the data suggest a need for action, state and local officials retain their traditional responsibility for investigating and intervening if necessary, although CDC will assist if invited.

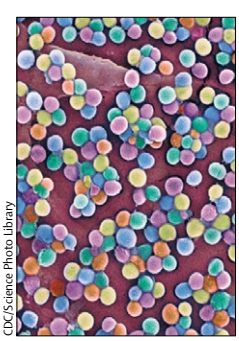
Since 2003, BioSense has collected data from veterans' and Department of Defense (DOD) hospitals and other DOD medical facilities plus a chain of medical labs. Last year it expanded to include several civilian hospitals. Additional institutions are being added to the network, and data are now being transmitted to the CDC every 15 minutes. Data include no information that could identify individual patients, but comprise reports on chief complaint, demographics, diagnosis at discharge, vital signs, physician diagnosis, discharge summary, procedures ordered, microbiology results, and pharmacy and radiology orders and results.

"We believe [BioSense] is useful not just for event detection but as a window on community health in real time," Steele said. The point is to be able to act on potential emergencies.

Mostashari is pleased that BioSense is planning to hire 28 people with expertise in epidemiology, statistics, and informatics to deal with the complexity of its new information.

Tabitha M Powledge

UK MRSA treatment guidelines: update



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For **Gemmel and colleagues' guidelines** see *J Antimicrob Chemother* 2006; **57:** 589–608; DOI:10.1093/jac/dkl017

For **Brown and colleagues' guidelines** see *J Antimicrob Chemother* 2005; **56:** 1000–18; DOI:10.1093/jac/dki372

For the **Joint MRSA Working Party Subgroup A's guidelines** see *J Hosp Infect* 2006; **63S:** S1–S44; DOI:10.1016/j.jhin.2006.01.001

For the **accompanying systematic review** see *J Hosp Infect* 2006; **63S:** S45–S70; DOI:10.1016/j.jhin.2006.01.002

After a gap of 8 years since the last guidelines, the UK now has three sets of weighty studies giving guidance on how to deal with meticillin-resistant *Staphylococcus aureus* (MRSA), all published within the past 5 months by the Joint Working Party of the British Society for Antimicrobial Chemotherapy.

Rod Warren (Department of Microbiology, Royal Shrewsbury Hospital, Shrewsbury, UK), corresponding author on the set of guidelines that looks at prevention and treatment with antibiotics points out that Derek Brown's team published the first set—on how to reliably detect an MRSA colonisation—in December last year. The third, just published this month by the Joint MRSA Working Party Subgroup A, Prevention and Control of MRSA, deals with the infection control guidance and strategies for preventing spread of the organism or infection with it. This was co-published with a systematic review, commissioned to provide guideline developers with an overview of the quality and range of evidence available to underpin the proposed revised guidance.

"The previous guidelines published in the early 1990s did not separate out these strands but concentrated on the last element—ie, infection control guidance and recommended a 'search and destroy' approach", explains Warren. He stresses that all the new guidelines are specific to the UK, "particularly the prophylaxis and therapy guidelines, as the licensed list of antibiotics is not the same for the US and UK and the common resistance patterns of MRSA also differ from country to country." Similarly, he adds, the infection control guidance may not be the same for low prevalence countries as for high prevalence countries such as the UK.

Jan Kluytmans (Laboratory for Microbiology and Infection Control, Amphia Hospital, Breda, Netherlands) agrees and points out that, in countries like the Netherlands and Denmark, "we still have a low prevalence and use the 'search and destroy' strategy. In my opinion, the evidence that this strategy is effective in a low prevalence setting is circumstantial, and it will probably never be fully evidence-based because of the many factors that have to be controlled." Kluytmans thinks that the new UK guidelines offer a good basis for successful control of MRSA in a high prevalence setting. However, although he regards the discussions on the scientific value of the many recommendations in the new guidelines on infection control guidance as important, he warns that we should not forget the real issue: "Implementation is the true challenge for the future and I personally doubt whether widespread execution of many of these measures is even feasible".

Kathryn Senior